

CERTIFICATE OF DEATH

Reg. Dist. No.

01170

1. PLACE OF DEATH a. COUNTY Talbot Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Talbot Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe, Md.				c. LENGTH OF STAY IN TB 23 Years.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				/d. STREET ADDRESS None			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Hans - Asmussen				4. DATE OF DEATH Month Day Year 1 30 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Asmuss Asmussen				14. MOTHER'S MAIDEN NAME Marie Jensen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Le Compte Funeral Service, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY OCCLUSION DUE TO (c) ARTERIOSCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH 2 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 1954 to JAN. 30 1960 , that I last saw the deceased alive on JAN. 30 1960 , and that death occurred at 5:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald F. Bartley M.D.				ADDRESS (Street, city or town, state) 9 N. HANSON ST. EASTON, MD.		DATE SIGNED 1-30-60	
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/60		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park.		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				24a. REC'D BY REGISTRAR DATE FEB 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL: After death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

1197 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BIO VISTA NURSING HOME</u>		d. STREET ADDRESS <u>3411 - Brothers pl SE</u>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>M.</u> Last <u>BADGER</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 31 - 1872</u>
9. AGE (In years, last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Withrup</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u>Donald R. Curry</u>	
17. INFORMANT <u>Donald R. Curry</u>		Address <u>Seneca #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary artery d</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition - coarctation - severe</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-20</u> , 19 <u>60</u> to <u>1-30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>60</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Guy M Reeser</u>		DATE SIGNED <u>1-30-60</u>	
PHYSICIAN'S NAME (Type) <u>Guy M Reeser</u>		ADDRESS (Street, city or town, state) <u>St Michael Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb 2 - 60</u>		22b. DATE THEREOF <u>Feb 2 - 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros</u>		ADDRESS <u>1661 Gd Hope Rd</u>	
24a. REC'D BY REGISTRAR <u>FEB 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

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1171 CERTIFICATE OF DEATH

Reg. Dist. No.

01172

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MR. DANIEL J. BALL		4. DATE OF DEATH JAN 30 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 21, 1874
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (State or foreign country) NEAVITT, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DAWSON BALL		14. MOTHER'S MAIDEN NAME ISABELLE HUNT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. — ?	
17. INFORMANT MRS. MARY C. BALL, NEAVITT, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) 1 wk. 5-10 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 20 Jan 1960 to 30 Jan 1960 , that I last saw the deceased alive on 30 Jan 1960 and that death occurred at 1:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Lane Wroth		DATE SIGNED 1-31-60	
PHYSICIAN'S NAME (Type) R. LANE WROTH		ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-2-60	22c. NAME OF CEMETERY OR CREMATORY Neavitt Cemetery	22d. LOCATION (City, town, or county) (State) Neavitt Md.
23. FUNERAL DIRECTOR'S SIGNATURE Samuel Harrison		ADDRESS St. Michaels	
24a. REC'D BY REGISTRAR FEB 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1173 CERTIFICATE OF DEATH

Reg. Dist. No.

01174

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN <u>3 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Wye Mills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		/d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Wilbert</u> Middle <u>Brown</u> Last <u>JR</u>		4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 30, 1919</u>
9. AGE (In years last birthday) yrs. <u>5</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>MARYLAND - Talbot</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Guiffin</u>		14. MOTHER'S MAIDEN NAME <u>Helen Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Helen Brown, Wye Mills, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>492 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2195 Washington St. Wye Mills Md.</u> ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. PHYSICIAN'S NAME (Type) <u>Easton Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sandtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hillshore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Pashell, Easton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2080182XV5

1173 CERTIFICATE OF DEATH

Age 20

Sex M

Occupation

Residence

Married

Signature

Date

Place

Signature

Date

Place

Signature

Date

Place

Signature

Date

Place

1174 CERTIFICATE OF DEATH

01175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>42 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
				d. STREET ADDRESS <u>719 D St. N.E. Apt 202</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James R. BRYAN</u>				4. DATE OF DEATH Month Day Year <u>Jan 13 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1905</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cran operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William A Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Baynard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Bryan</u>		17. INFORMANT Address <u>Helene Bryan, wife - none</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>JAN 11, 1960</u> , 19 <u>60</u> , to <u>Jan 13</u> , 19 <u>60</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2 25</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>1/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edford Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Edford Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Maurice E. Newman & Son Easton, Md.</u>				24. REC'D BY REGISTRAR DATE <u>JAN 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>		

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 17

CERTIFICATE OF DEATH

Reg. Dist. No.

01176

1175

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>6 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elliott</u> Middle <u>M</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-94</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Virginia</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Elliott M. Campbell</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA D. W. away</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Mrs. Samuel King <u>Alexandria, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>332x</u> DUE TO (c) <u>332x</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____ and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. H. Schmidt</u>		DATE SIGNED <u>29 S. Westinghouse St. 29 Dec 60</u>	
PHYSICIAN'S NAME (Type) <u>E. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>JAN 29 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oreord Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bxford, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Dewar</u>		24a. REC'D BY REGISTRAR <u>1 '60</u> 24b. REGISTRAR'S SIGNATURE <u>C. E. K.</u>	

Page 4
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

1175

IN SENATE

JANUARY 10, 1902

REPORT OF THE

COMMISSIONER OF

THE LAND OFFICE

IN RESPONSE TO A

RESOLUTION PASSED

BY THE SENATE

APRIL 1, 1901

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

PRINTING OFFICE

1902

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1176 CERTIFICATE OF DEATH

Reg. Dist. No.

01177

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>611 South St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Dean</u> Last <u>Dean</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Breeding</u>		14. MOTHER'S MAIDEN NAME <u>Anna Stanley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. A.J. Stanley, Jr.</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Toxemia</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Infected Decubitus Ulcer</u> DUE TO (c) <u>Parkinson's Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/19/59</u> to <u>1/1/60</u> , that I last saw the deceased alive on <u>1/1/60</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>L. J. Ealseder</u> M.D.		<u>12 N. HANSON</u>	
PHYSICIAN'S NAME (Type) <u>Dr. L. J. Ealseder</u>		<u>EASTON, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>JAN. 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	22d. LOCATION (City, town, of county) (State) <u>Easton Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman & Son</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1177 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>9 days.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. STREET ADDRESS <i>Queen Anne Hotel</i>			
3. NAME OF DECEASED (Type or print) First <i>Harvey</i> Middle <i>P.</i> Last <i>Elliott</i>				4. DATE OF DEATH Month <i>January</i> Day <i>1</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 2, 1889</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SAME</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Elliott</i>				14. MOTHER'S MAIDEN NAME <i>Lottie Abbott</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>212-16-1499</i>		17. INFORMANT <i>Mrs. Hazel Stovall</i> Address <i>Oxford Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> <i>141.9</i> DUE TO <i>Carcinoma of tongue</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO <i></i> (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> to <i>1960</i> , that I last saw the deceased alive on <i>Jan 1, 1960</i> and that death occurred at <i>3:00 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i> M.D.				ADDRESS (Street, city or town; state) <i>219 S. Washington St. 2nd fl. Easton, Md.</i> DATE SIGNED <i>Jan 5, 1960</i>			
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>				ADDRESS <i>Easton, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<i>Burial</i>	<i>Jan 4, 1960</i>	<i>Oxford Cemetery</i>		<i>Oxford Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin E. Newman & Son</i>				24a. REC'D BY REGISTRAR DATE <i>JAN 5 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1178 CERTIFICATE OF DEATH

Reg. Dist. No.

01179

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>11 days - 12 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>214 S. 2nd Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John H. Emerson</u>	4. DATE OF DEATH <u>January 21 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 22 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Month Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Mr. Eldridge Emerson</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Ellen Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Informant Mrs. Nits Emerson - Denton.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential hypertension, Chronic duodenal ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year. Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Jan</u> 19 <u>60</u> to <u>21 Jan</u> 19 <u>60</u> , that I last saw the deceased alive on <u>20 Jan</u> 19 <u>60</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Dr. Thurston Harrison</u>		<u>Easton, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Jan 22 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Howard for Denton</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 22 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

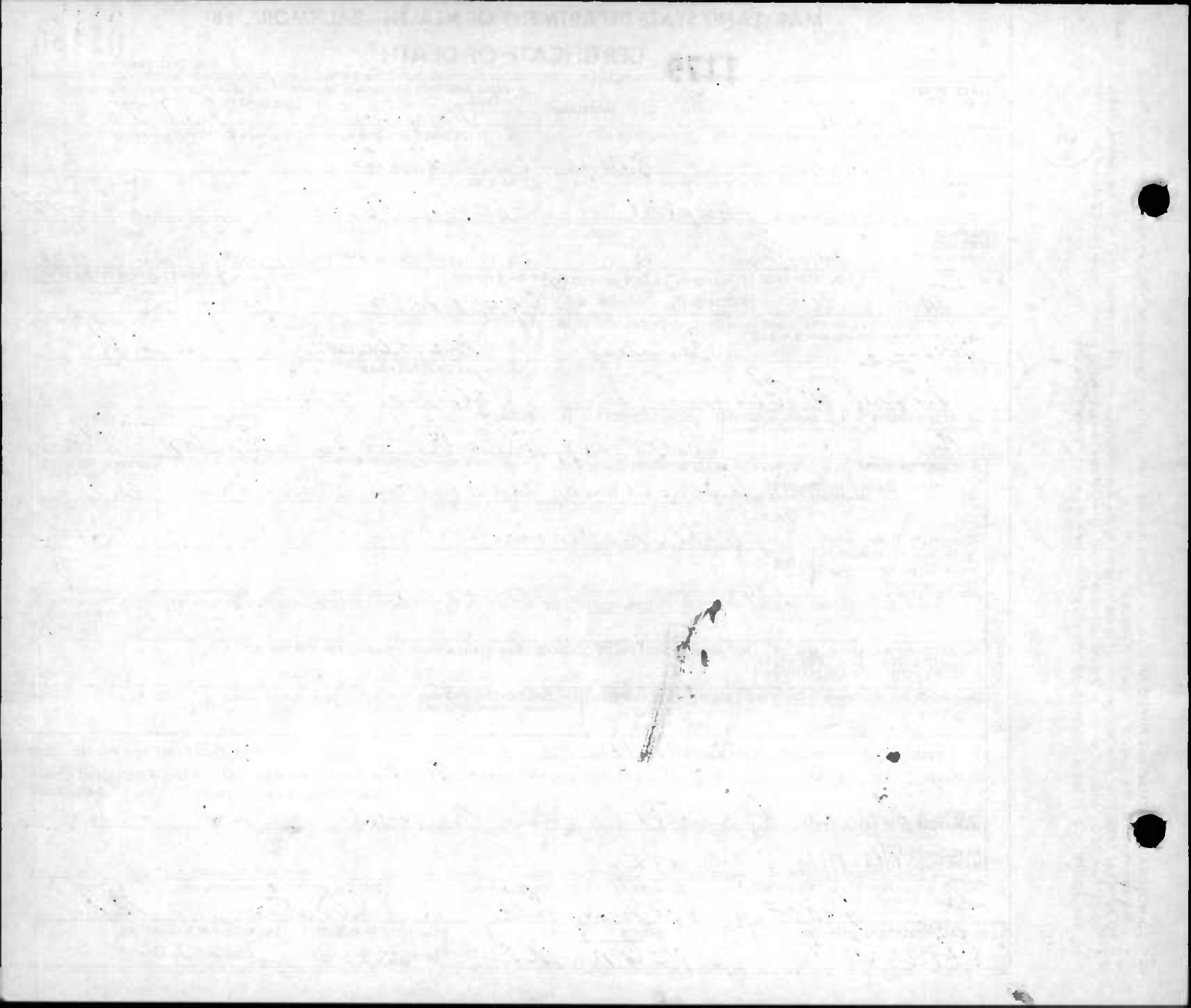
01180

1179

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J</u> Last <u>Ewing</u>		4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1940</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>25</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert W. Ewing</u>		14. MOTHER'S MAIDEN NAME <u>Catherine J. Ewing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>460-1247</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis heart disease & heart block.</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1939</u> , to <u>1-26</u> , 19 <u>40</u> that I last saw the deceased alive on <u>1-26</u> , 19 <u>40</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Winters</u> M.D. <u>Easton</u> <u>MD</u>		DATE SIGNED <u>1-26-40</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM L. WINTERS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 29, 1940</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Beck</u> ADDRESS <u>Easton MD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '40</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1180 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY TAIBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TAIBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 26 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 127 S. HARRISON ST			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Bertha First A Middle FAIRBANK Last				4. DATE OF DEATH JAN Month 8 Day 19 Year 60			
5. SEX Fe		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1895	
				9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME Charles R. Leonard				14. MOTHER'S MARRIED NAME Ida Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT Miss John Laubdin Address Easton Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Coronary thrombosis 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (2) Pneumonia due to a ruptured gall bladder DUE TO (c) (3) chronic cholecystitis							INTERVAL BETWEEN ONSET AND DEATH 4-5 days.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 19 47 , to Jan 19 60 , that I last saw the deceased alive on Jan 19 60 , and that death occurred at 2:16 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Easton, Maryland DATE SIGNED 1/15/60							
ACTUAL SIGNATURE Thurston Harrison M.D.							
PHYSICIAN'S NAME (Type) THURSTON HARRISON				EASTON, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		1/11/60		Spring Hill		Easton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice F. Newman & Son ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR DATE JAN 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1900		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
Clerk		Heart Disease		Home		Jan 20, 1945		10:30 AM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
16. MEDICAL HISTORY		17. SOCIAL HISTORY		18. FAMILY HISTORY		19. PRESENT ILLNESS		20. POST-MORTEM	
[Text]		[Text]		[Text]		[Text]		[Text]	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness.

2. The cause of death should be stated in as many words as possible, giving the immediate cause, the remote cause, and the mode of death.

3. The place of death should be stated as home, hospital, or other institution.

4. The date and time of death should be stated as accurately as possible.

5. The signature of the physician or other qualified person should be written in ink.

6. The signature of the registrar should be written in ink.

7. The signature of the witnesses should be written in ink.

8. The signature of the deceased should be written in ink.

9. The signature of the next of kin should be written in ink.

10. The medical history should be written in ink.

11. The social history should be written in ink.

12. The family history should be written in ink.

13. The present illness should be written in ink.

14. The post-mortem should be written in ink.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01182

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1199

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXFORD		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) TRED AVON RIVER		d. STREET ADDRESS OXFORD	
3. NAME OF DECEASED (Type or print) JOHN WESLEY FORREST		4. DATE OF DEATH Month JAN Day 19 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1905
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waterman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ernest B. Forrest		14. MOTHER'S MAIDEN NAME Anna Eileen Pasquith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-14-2776	
17. INFORMANT Mr. Benjamin Forrest		Address Oxford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH IMMED.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FOUND FLOATING FACE-UP IN TRED AVON RIVER			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) V. SUP. HISTORY OF PALLOR AND MALAISE	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Lewis Welty		DATE SIGNED 1-19-60	
EXAMINER'S NAME (Type) WELTY		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 21, 1960	22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery	22d. LOCATION (City, town, or county) (State) Oxford, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		24a. REC'D BY REGISTRAR 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

MEDICAL CERTIFICATION

1102

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNABOR 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: JOHN J. BROWN SEX: M AGE: 45 RACE: W

DATE OF DEATH: 11-11-1918 PLACE OF DEATH: At home

RESIDENT OF: 123 Main St., Boston, Mass.

CAUSE OF DEATH: Heart failure

DATE OF EXAMINATION: 11-11-1918 BY: Dr. J. B. Smith

PLACE OF EXAMINATION: At home

TIME OF EXAMINATION: 10:00 AM

TEMPERATURE: 100.0 PULSE: 100 RESPIRATION: 20

WEIGHT: 150 HEIGHT: 5' 8"

COMPLEXION: Good EYES: Blue HAIR: Brown

TEETH: Good NAILS: Good SKIN: Good

INTERNAL ORGANS: Normal

EXTERNAL ORGANS: Normal

DIAGNOSIS: Heart failure

REMARKS: None

SIGNATURE: Dr. J. B. Smith

DATE: 11-11-1918

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BARNABOR 12, AND A COPY IS TO BE SENT TO THE LOCAL HEALTH OFFICER.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1181 CERTIFICATE OF DEATH

Reg. Dist. No.

01183

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>7 Days-12 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington</u> 05 x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>519 Lincoln Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>-</u> Last <u>Gardy</u>				4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1901</u>			
9. AGE (In years last birthday) <u>52 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>2</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvage (Bay)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>			
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>									
13. FATHER'S NAME <u>Isaac Gardy</u>				14. MOTHER'S MAIDEN NAME <u>Hester Marie</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>-</u>					
17. INFORMANT <u>Patients Chart (Summary sheet)</u>				Address <u>Memorial Hospital</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrolyte Imbalance</u> 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis with occlusion</u> DUE TO (c) <u>?</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>12</u> Day <u>30</u> Year <u>1959</u> Hour a. m. <u>2:45</u> p. m. <u>AM</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>December 30, 1959</u> , to <u>January 6, 1960</u> , that I last saw the deceased alive on <u>January 6, 1960</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>J. B. Ambler</u>				ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>					
DATE SIGNED <u>Jan 7 1960</u>									
22a. BURIAL CREMATION, REMOVA (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-8-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U. S. Med. Med. School</u>			
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>				22e. (State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. Moore & Son</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 7 1960</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>									

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1182 CERTIFICATE OF DEATH

Reg. Dist. No.

01184

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> 09X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>UNKNOWN</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS R GRAVES</u>		4. DATE OF DEATH Month Day Year <u>1-4 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis M Graves</u>		14. MOTHER'S MAIDEN NAME <u>Lillian A. Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced bilateral pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>002X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>> 2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-29</u> , 19 <u>59</u> , to <u>1-3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>60</u> , and that death occurred at <u>2:49</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>202 Dover St.</u> DATE SIGNED <u>1-3-60</u>	
PHYSICIAN'S NAME (Type) <u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/6/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>2195 York Road, Sevier (Cambridge)</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

71

CERTIFICATE OF DEATH

1182

Reg. Dist. No.

1. NAME OF DECEASED ALBERT		2. SEX M		3. AGE 76	
4. PLACE OF BIRTH NEW YORK		5. DATE OF BIRTH JAN 10 1886		6. PLACE OF DEATH BALTIMORE	
7. NAME OF HUSBAND JANE		8. NAME OF WIFE ALBERT		9. NAME OF CHILD JANE	
10. NAME OF DECEASED ALBERT		11. NAME OF DECEASED JANE		12. NAME OF DECEASED ALBERT	
13. NAME OF DECEASED ALBERT		14. NAME OF DECEASED JANE		15. NAME OF DECEASED ALBERT	
16. NAME OF DECEASED ALBERT		17. NAME OF DECEASED JANE		18. NAME OF DECEASED ALBERT	
19. NAME OF DECEASED ALBERT		20. NAME OF DECEASED JANE		21. NAME OF DECEASED ALBERT	
22. NAME OF DECEASED ALBERT		23. NAME OF DECEASED JANE		24. NAME OF DECEASED ALBERT	
25. NAME OF DECEASED ALBERT		26. NAME OF DECEASED JANE		27. NAME OF DECEASED ALBERT	
28. NAME OF DECEASED ALBERT		29. NAME OF DECEASED JANE		30. NAME OF DECEASED ALBERT	
31. NAME OF DECEASED ALBERT		32. NAME OF DECEASED JANE		33. NAME OF DECEASED ALBERT	
34. NAME OF DECEASED ALBERT		35. NAME OF DECEASED JANE		36. NAME OF DECEASED ALBERT	
37. NAME OF DECEASED ALBERT		38. NAME OF DECEASED JANE		39. NAME OF DECEASED ALBERT	
40. NAME OF DECEASED ALBERT		41. NAME OF DECEASED JANE		42. NAME OF DECEASED ALBERT	
43. NAME OF DECEASED ALBERT		44. NAME OF DECEASED JANE		45. NAME OF DECEASED ALBERT	
46. NAME OF DECEASED ALBERT		47. NAME OF DECEASED JANE		48. NAME OF DECEASED ALBERT	
49. NAME OF DECEASED ALBERT		50. NAME OF DECEASED JANE		51. NAME OF DECEASED ALBERT	
52. NAME OF DECEASED ALBERT		53. NAME OF DECEASED JANE		54. NAME OF DECEASED ALBERT	
55. NAME OF DECEASED ALBERT		56. NAME OF DECEASED JANE		57. NAME OF DECEASED ALBERT	
58. NAME OF DECEASED ALBERT		59. NAME OF DECEASED JANE		60. NAME OF DECEASED ALBERT	
61. NAME OF DECEASED ALBERT		62. NAME OF DECEASED JANE		63. NAME OF DECEASED ALBERT	
64. NAME OF DECEASED ALBERT		65. NAME OF DECEASED JANE		66. NAME OF DECEASED ALBERT	
67. NAME OF DECEASED ALBERT		68. NAME OF DECEASED JANE		69. NAME OF DECEASED ALBERT	
70. NAME OF DECEASED ALBERT		71. NAME OF DECEASED JANE		72. NAME OF DECEASED ALBERT	
73. NAME OF DECEASED ALBERT		74. NAME OF DECEASED JANE		75. NAME OF DECEASED ALBERT	
76. NAME OF DECEASED ALBERT		77. NAME OF DECEASED JANE		78. NAME OF DECEASED ALBERT	
79. NAME OF DECEASED ALBERT		80. NAME OF DECEASED JANE		81. NAME OF DECEASED ALBERT	
82. NAME OF DECEASED ALBERT		83. NAME OF DECEASED JANE		84. NAME OF DECEASED ALBERT	
85. NAME OF DECEASED ALBERT		86. NAME OF DECEASED JANE		87. NAME OF DECEASED ALBERT	
88. NAME OF DECEASED ALBERT		89. NAME OF DECEASED JANE		90. NAME OF DECEASED ALBERT	
91. NAME OF DECEASED ALBERT		92. NAME OF DECEASED JANE		93. NAME OF DECEASED ALBERT	
94. NAME OF DECEASED ALBERT		95. NAME OF DECEASED JANE		96. NAME OF DECEASED ALBERT	
97. NAME OF DECEASED ALBERT		98. NAME OF DECEASED JANE		99. NAME OF DECEASED ALBERT	
100. NAME OF DECEASED ALBERT		101. NAME OF DECEASED JANE		102. NAME OF DECEASED ALBERT	

NOTED - 10/10/1910

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

1183 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>24 hours - 33 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Phillip</i> Middle <i>Louis Randall</i> Last <i>Hall</i>		4. DATE OF DEATH Month <i>January</i> Day <i>30</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>?</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Phillip Louis Randall Hall</i>		14. MOTHER'S MAIDEN NAME <i>Anna Eliza Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs. Olga Hall, Easton Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>330X</i> DUE TO <i>Aspirations Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <i>Subarachnoid Hemorrhage</i> DUE TO <i>24h.</i> (c) <i>24h.</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1/29</i> , 19 <i>60</i> , to <i>1/30</i> , 19 <i>60</i> that I last saw the deceased alive on <i>1/30</i> , 19 <i>60</i> , and that death occurred at <i>12:35 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. Lane Wroth</i> M.D.		DATE SIGNED <i>2-1-60</i>	
PHYSICIAN'S NAME (Type) <i>R. LANE WROTH - St. Michaels Md</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>Feb 2, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cherrytown Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Easton, R.F.D. Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. ...</i> ADDRESS <i>Easton Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 23 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. ...</i>

1

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

5831

1184 CERTIFICATE OF DEATH

01185

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL				d. STREET ADDRESS TAYLORS AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BOBBY Middle BOY Last HENRY				4. DATE OF DEATH Month JANUARY Day 13 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 10, 1960	
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 6		IF UNDER 24 HRS. Days 6 Hours 6 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD HENRY				14. MOTHER'S MAIDEN NAME LORRAINE ELIZABETH O'BRIEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT "MOTHER"		Address HURLOCK, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sub-dural hemorrhage DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. C. H. Selznick				ADDRESS (Street, city or town, state) 2195 West 111th St. 13th fl. Md.			
DATE SIGNED Jan 13 1960							
PHYSICIAN'S NAME (Type) E. C. H. Selznick				Canton 16 Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 14, 1960		22c. NAME OF CEMETERY OR CREMATORY J.O.U.A.M. CEMETERY		22d. LOCATION (City, town, or county) PRESTON (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton & Son				ADDRESS Federalburg		24a. REC'D BY REGISTRAR JAN 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Pious			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

VS. A15 (4)
15M 9/55

208017 IXVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 1-27-60 et

CERTIFICATE OF DEATH

01186

Reg. Dist. No.

1185

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> d. STREET ADDRESS <u>Thompson St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Augusta</u> Hopkins First Middle Last		4. DATE OF DEATH Month <u>JAN</u> Day <u>17</u> Year <u>1960</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>DEC 25, 1885</u> 9. AGE (In years last birthday) <u>74</u> yrs. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Elisab Jewell</u> 14. MOTHER'S MAIDEN NAME <u>Lucy Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>213-18-4293A</u> INFORMANT <u>Mildred M. Smith, St. Michaels, Md.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Diabetes Mellitis</u> DUE TO (c) <u>Hypertensive Cardiovascular</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>15 Jan, 1960</u> to <u>17 Jan, 1960</u> that I last saw the deceased alive on <u>17 Jan</u> and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>R. Lane Wroth</u> DATE SIGNED <u>Box 487, St. Michaels, Md 1-17-60</u> PHYSICIAN'S NAME (Type) <u>R. LANE WROTH, MD</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Jan 20, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Colored Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels</u> <u>md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Ambrose Harrison, St. Michaels</u> ADDRESS <u>md</u>		24a. REC'D BY REGISTRAR <u>JAN 20 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1990

1992

1200 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wittman		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last JACKSON		4. DATE OF DEATH Month January Day 11, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1901
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Wittman, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George D. Jackson	
14. MOTHER'S MAIDEN NAME Ada M. Jackson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. INFORMANT Address George L. Jackson, Bozman, Maryland		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 157X DUE TO Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1477 (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 Dec , 19 58 , to 11 January 1960 , that I last saw the deceased alive on 10 Jan , 19 60 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md DATE SIGNED 1-11-60 ACTUAL SIGNATURE R. Lane Wroth M.D. PHYSICIAN'S NAME (Type) R. Lane Wroth, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 13, 1960	
22c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery		22d. LOCATION (City, town, or county) (State) St. Michaels, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hambaton Harrison, St. Michaels, Md		24a. REC'D BY REGISTRAR DATE JAN 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1500

Tabbot

Barfield

1901

Wittner

also

Wittner

January 11, 1901

JACKSON

M.

CHAMBERLAIN

May 3, 1901

Wittner

Wittner

USA

Wittner, Maryland

Wittner

Wittner

Wittner, Maryland

Wittner, Maryland

Wittner, Maryland

Wittner

Wittner, Maryland

Wittner, Maryland

Wittner, Maryland

1186 CERTIFICATE OF DEATH

01188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>09X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Eleanor</u> Last <u>Kenworthy</u>		4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator of Laura E. Beauty Shop</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Philadelphia, Pa.</u>	
13. FATHER'S NAME <u>Wayne D. Mower</u>		14. MOTHER'S MAIDEN NAME <u>Eva M. Shupe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		ADDRESS (Street, city or town, state) <u>202 Dover St. Easton, Md.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>2-1-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 2, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harleigh Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Camden, New Jersey</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Trumpton & Son, Federalburg, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1188

NEW YORK

STATE OF NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1187 CERTIFICATE OF DEATH

Reg. Dist. No.

01189

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels Road Rural Easton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>114 N. Harrison St.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Jerome</u> Middle <u>Garrett</u> Last <u>Lister</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James A. Lister</u>		14. MOTHER'S MAIDEN NAME <u>Martha M. Catup</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs J B Lister</u>		Address <u>Rural Easton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19 <u>56</u> , to <u>1-2-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-1-</u> , 19 <u>60</u> , and that death occurred at <u>14</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>B Cox</u> M.D. <u>Easton Md</u>			
PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan. 4, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nellie Galt</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 6 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1188 CERTIFICATE OF DEATH

01190

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Memorial Hospital</u>		d. STREET ADDRESS <u>6004 Market Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Mr. Casper</u> Middle <u>Meeks</u> Last <u>Meeks</u>		4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 31, 1889</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed - -</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Mr. Acquilla F. Meeks</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cokman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wrs. John Barwick</u> Address <u>Denton, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecholelithiasis, Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>< 1 hr.</u> <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Robert W. Trever</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Dr. Robert Trever</u> <u>Easton, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 17, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton Greenboro</u>	22d. LOCATION (City, town, or county) (State) <u>Greenboro Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. King Moore</u> ADDRESS <u>Denton Md</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>
		DATE <u>JAN 19 '60</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>		<p>9. PLACE OF DEATH</p>		<p>10. DATE OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CLERK</p>		<p>15. SIGNATURE OF REGISTRAR</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESSES</p>		<p>18. SIGNATURE OF PHYSICIAN</p>		<p>19. SIGNATURE OF CLERK</p>		<p>20. SIGNATURE OF REGISTRAR</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESSES</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF CLERK</p>		<p>25. SIGNATURE OF REGISTRAR</p>	
<p>26. SIGNATURE OF DECEASED</p>		<p>27. SIGNATURE OF WITNESSES</p>		<p>28. SIGNATURE OF PHYSICIAN</p>		<p>29. SIGNATURE OF CLERK</p>		<p>30. SIGNATURE OF REGISTRAR</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF WITNESSES</p>		<p>33. SIGNATURE OF PHYSICIAN</p>		<p>34. SIGNATURE OF CLERK</p>		<p>35. SIGNATURE OF REGISTRAR</p>	
<p>36. SIGNATURE OF DECEASED</p>		<p>37. SIGNATURE OF WITNESSES</p>		<p>38. SIGNATURE OF PHYSICIAN</p>		<p>39. SIGNATURE OF CLERK</p>		<p>40. SIGNATURE OF REGISTRAR</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESSES</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF CLERK</p>		<p>45. SIGNATURE OF REGISTRAR</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESSES</p>		<p>48. SIGNATURE OF PHYSICIAN</p>		<p>49. SIGNATURE OF CLERK</p>		<p>50. SIGNATURE OF REGISTRAR</p>	
<p>51. SIGNATURE OF DECEASED</p>		<p>52. SIGNATURE OF WITNESSES</p>		<p>53. SIGNATURE OF PHYSICIAN</p>		<p>54. SIGNATURE OF CLERK</p>		<p>55. SIGNATURE OF REGISTRAR</p>	
<p>56. SIGNATURE OF DECEASED</p>		<p>57. SIGNATURE OF WITNESSES</p>		<p>58. SIGNATURE OF PHYSICIAN</p>		<p>59. SIGNATURE OF CLERK</p>		<p>60. SIGNATURE OF REGISTRAR</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESSES</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF CLERK</p>		<p>65. SIGNATURE OF REGISTRAR</p>	
<p>66. SIGNATURE OF DECEASED</p>		<p>67. SIGNATURE OF WITNESSES</p>		<p>68. SIGNATURE OF PHYSICIAN</p>		<p>69. SIGNATURE OF CLERK</p>		<p>70. SIGNATURE OF REGISTRAR</p>	
<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESSES</p>		<p>73. SIGNATURE OF PHYSICIAN</p>		<p>74. SIGNATURE OF CLERK</p>		<p>75. SIGNATURE OF REGISTRAR</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESSES</p>		<p>78. SIGNATURE OF PHYSICIAN</p>		<p>79. SIGNATURE OF CLERK</p>		<p>80. SIGNATURE OF REGISTRAR</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESSES</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF CLERK</p>		<p>85. SIGNATURE OF REGISTRAR</p>	
<p>86. SIGNATURE OF DECEASED</p>		<p>87. SIGNATURE OF WITNESSES</p>		<p>88. SIGNATURE OF PHYSICIAN</p>		<p>89. SIGNATURE OF CLERK</p>		<p>90. SIGNATURE OF REGISTRAR</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESSES</p>		<p>93. SIGNATURE OF PHYSICIAN</p>		<p>94. SIGNATURE OF CLERK</p>		<p>95. SIGNATURE OF REGISTRAR</p>	
<p>96. SIGNATURE OF DECEASED</p>		<p>97. SIGNATURE OF WITNESSES</p>		<p>98. SIGNATURE OF PHYSICIAN</p>		<p>99. SIGNATURE OF CLERK</p>		<p>100. SIGNATURE OF REGISTRAR</p>	

1. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

2. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

3. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

4. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

5. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

6. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

7. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

8. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

9. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

10. This is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

CERTIFICATE OF DEATH

Reg. Dist. No.

01191

1201

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St. Michaels</u>				c. LENGTH OF STAY IN 1b <u>30 da</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>				d. STREET ADDRESS <u>1 Davis Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deo Veste Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>M.</u> Last <u>Preston</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1887</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clean House</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Scott Gibbs</u>			
14. MOTHER'S MAIDEN NAME <u>Julia Montgomery</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mrs. D. Temple Preston</u> Address <u>White Hall Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>coronary severe progressive</u> DUE TO (c) <u>adenocarcinoma colon = widespread</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>abdominal, liver metastatic cl.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12-4-1959</u> , to <u>1-17-1960</u> , that I last saw the deceased alive on <u>1-17-1960</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Guy M. Reeser Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>St Michaels Md</u>			
DATE SIGNED <u>1-18-60</u>							
PHYSICIAN'S NAME (Type) <u>Guy M Reeser Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan. 19, 60</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	
22d. LOCATION (City, town, or county) <u>Easton</u>				22e. (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert</u> ADDRESS <u>Easton Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kame</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01192

1189

Reg. Dist. No.

FOR STATE
HEALTH DEPT

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MD</u> b. COUNTY <u>Queen Anne's</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>22 Hours-15 min. (Kent Narrows)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Graisonville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital-Easton, Md.</u>			d. STREET ADDRESS <u>17X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert Royster</u>			4. DATE OF DEATH <u>January 24</u> 19 <u>60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1921</u>		9. AGE (In years and birthday) <u>37</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>David Royster</u>			14. MOTHER'S MAIDEN NAME <u>Emma</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>David Royster</u> Address <u>N.C. Rout 1, Milton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd Degree Burns of Face, Head, Back</u> 916.0 DUE TO (b) <u>Arms,</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Smoke inhalation</u> DUE TO <u>23 hrs.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>23 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Asleep in shanty which caught fire.</u>			
20c. TIME OF INJURY Month, Day, Year <u>1/23</u> 19 <u>60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Kent Narrows</u>		20f. (City or town) <u>Graisonville</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Irvin S. Hoyt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/24/60</u>	
EXAMINER'S NAME (Type) <u>Dr. Irvin S. Hoyt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Milton N.C.</u>		22d. LOCATION (City, town, or county) <u>Milton N.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Halstead</u>		ADDRESS <u>918 Peach Hill Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 27 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	

FOR NAME
HEALTH DIST

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

Items 18&2. Film 260 4-11-60 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1190

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03798

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton High School</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u> d. STREET ADDRESS <u>1 212 Prospect Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wayne Benjamin Russ</u>		4. DATE OF DEATH <u>Jan 11 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1942</u>
9. AGE (In years last birthday) <u>17</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>High School student</u>	
11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Benjamin Russ</u>		14. MOTHER'S MAIDEN NAME <u>Alma Rimmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (es, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>ukn.</u>	
17. INFORMANT <u>J. Benjamin Russ, Easton, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vago-vagal spasm</u> 780.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>212 Prospect Ave.</u> INTERVAL BETWEEN ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Died suddenly in gym class</u>	
20c. TIME OF INJURY Month, Day, Year <u>1-11-1960</u> Hour a. m. <u>11:30 P.M.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>School</u>		20f. (City or town) <u>EASTON</u> (County) <u>Tal</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Louis Merty</u>		DATE SIGNED <u>1-12-60</u>	
EXAMINER'S NAME (Type) <u>INIELTY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Frampton Carroll</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 22 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>			

W. Frampton Carroll

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN lb 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton d. STREET ADDRESS 114 Biery St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MR Oscar Middle C. Last Schells		4. DATE OF DEATH Month 1 Day 28 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 3 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Hardware Store	11. BIRTHPLACE (State or foreign country) Neeritt Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Schells	
14. MOTHER'S MAIDEN NAME Emily Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —	
16. SOCIAL SECURITY NO. 213-01-8441		INFORMANT Mrs Katie Schells Address Easton Md	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Instantaneous 260 X DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes Mellitus (b) Supracondylar Amputation, left, for diabetic gangrene, foot (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Instant Yrs Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Supracondylar Amputation, left, for diabetic gangrene, foot		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) EASTON, MD DATE SIGNED 1/28/60			
ACTUAL SIGNATURE Shepherd M.D.		DATE SIGNED 1/28/60	
PHYSICIAN'S NAME (Type) SHEPARD KRECH JR			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-60	
22c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery		22d. LOCATION (City, town, or county) (State) Easton Md	
23. FUNERAL DIRECTOR'S SIGNATURE A. Hamilton Harrison, St. Michaels, Md		24a. REC'D BY REGISTRAR DATE FEB 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03799

1202 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural- Cordova		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural- Cordova	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD		d. STREET ADDRESS RFD	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Adolph Last Schlotzhauer		4. DATE OF DEATH Month January Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.	IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Milk	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chris Schlotzhauer		14. MOTHER'S MAIDEN NAME Bertha Plugge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 214-36-5338	
17. INFORMANT Clara Neal Schlotzhauer, rural Cordova		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410x Congestive heart failure DUE TO (b) Rheumatic heart disease with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) mitral stenosis and insufficiency DUE TO (c) 50 years		INTERVAL BETWEEN ONSET AND DEATH 11 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1959 to Mar. 25, 1959 , that I last saw the deceased alive on Mar. 25, 1959 , and that death occurred at 10:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Kurt Lederer		M.D.	
PHYSICIAN'S NAME (Type) Kurt L. Lederer, M.D.		Hillsboro, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/6/60	22c. NAME OF CEMETERY OR CREMATORY St. Paul Church Cemt.	22d. LOCATION (City, town, or county) (State) Cordova, RD, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Frampton Carroll		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE MAR 2 2 '60		24b. REGISTRAR'S SIGNATURE John S. Haul	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

502

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1900"]		PLACE OF BIRTH [Faint text, possibly "Maryland"]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "11/1/1945"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]		CERTIFICATE OF DEATH [Faint text]	



1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and should be filed with the local health department or the State Department of Health. It is a legal document and its contents are subject to the laws of the State of Maryland.

2. The cause of death should be stated in as much detail as possible, and should be based on the physician's own knowledge and the information furnished by the family. It should be stated in the following order: (a) the immediate cause of death, (b) the underlying cause of death, and (c) the contributing causes of death.

3. The manner of death should be stated as either "Natural", "Accidental", "Suicidal", or "Homicidal".

4. The place of death should be stated as either "Home", "Hospital", "Nursing Home", "Prison", or "Other".

5. The date and time of death should be stated as accurately as possible.

6. The signature of the physician or other qualified person who attended the deceased during his last illness is required. It should be signed in ink and should be accompanied by the physician's name and title.

7. The signature of the registrar is required. It should be signed in ink and should be accompanied by the registrar's name and title.

8. The signature of the witness is required. It should be signed in ink and should be accompanied by the witness's name and title.

9. The signature of the witness is required. It should be signed in ink and should be accompanied by the witness's name and title.

10. The signature of the witness is required. It should be signed in ink and should be accompanied by the witness's name and title.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1192 CERTIFICATE OF DEATH

01194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville, Md. 17x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>419 So. Commerce St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Scott</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 23, 1896</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Edward Scott</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>220-32-2413</u>		17. INFORMANT <u>Killer Scott, wife</u> Address <u>Centreville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X CEREBRAL HEMORRHAGE and</u> DUE TO <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>EDEMA</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u> <u>YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>1/3/1960</u> to <u>1/3/1960</u> that I last saw the deceased alive on <u>1/3/1960</u> and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Kent Young</u> M.D.				ADDRESS (Street, city or town, state) <u>105 Chesterfield Ave. Centreville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. KENT YOUNG</u>				DATE SIGNED <u>1/4/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centreville (col) Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walby, Chesterton, Md.</u> ADDRESS <u>Walby</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JAN 8 '60</u>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10-1

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		1910		Baltimore, Md.		Carpenter		Married		White		Roman Catholic		High School		Middle Class		Baltimore, Md.		1955		10:30 AM		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris			
21. PLACE OF INTERMENT		22. NAME OF INTERMENT		23. DATE OF INTERMENT		24. TIME OF INTERMENT		25. PLACE OF BURIAL		26. NAME OF BURIAL		27. DATE OF BURIAL		28. TIME OF BURIAL		29. PLACE OF CREMATION		30. NAME OF CREMATION		31. DATE OF CREMATION		32. TIME OF CREMATION		33. PLACE OF URN		34. NAME OF URN		35. DATE OF URN		36. TIME OF URN		37. PLACE OF REINTERMENT		38. NAME OF REINTERMENT		39. DATE OF REINTERMENT		40. TIME OF REINTERMENT	
St. Mary's Cemetery		Plot 123		1955		10:30 AM		St. Mary's Cemetery		Plot 123		1955		10:30 AM																									

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death.

2. The cause of death should be stated in as much detail as possible, and should include the immediate cause, the underlying cause, and any other significant conditions.

3. The manner of death should be stated as natural, accidental, suicidal, homicidal, or undetermined.

4. The signature of the physician or other qualified person should be written in ink.

5. The signature of the registrar should be written in ink.

6. The signature of the witnesses should be written in ink.

7. The signature of the deceased should be written in ink.

8. This certificate is to be filed in the office of the Registrar of Deaths, Baltimore, Md.

9. A copy of this certificate is to be sent to the family of the deceased.

10. A copy of this certificate is to be sent to the local health department.

11. A copy of this certificate is to be sent to the State Department of Health.

12. A copy of this certificate is to be sent to the Federal Bureau of Investigation.

13. A copy of this certificate is to be sent to the National Bureau of Health Statistics.

14. A copy of this certificate is to be sent to the National Institute of Health.

15. A copy of this certificate is to be sent to the National Cancer Institute.

16. A copy of this certificate is to be sent to the National Heart Institute.

17. A copy of this certificate is to be sent to the National Institute of Mental Health.

18. A copy of this certificate is to be sent to the National Institute of Child Health and Human Development.

19. A copy of this certificate is to be sent to the National Institute of Environmental Health Sciences.

20. A copy of this certificate is to be sent to the National Institute of Drug Abuse.

21. A copy of this certificate is to be sent to the National Institute of Diabetes and Digestive and Kidney Diseases.

22. A copy of this certificate is to be sent to the National Institute of Neurological Disorders and Stroke.

23. A copy of this certificate is to be sent to the National Institute of Allergy and Infectious Diseases.

24. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

25. A copy of this certificate is to be sent to the National Institute of Biotechnology.

26. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

27. A copy of this certificate is to be sent to the National Institute of Biotechnology.

28. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

29. A copy of this certificate is to be sent to the National Institute of Biotechnology.

30. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

31. A copy of this certificate is to be sent to the National Institute of Biotechnology.

32. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

33. A copy of this certificate is to be sent to the National Institute of Biotechnology.

34. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

35. A copy of this certificate is to be sent to the National Institute of Biotechnology.

36. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

37. A copy of this certificate is to be sent to the National Institute of Biotechnology.

38. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

39. A copy of this certificate is to be sent to the National Institute of Biotechnology.

40. A copy of this certificate is to be sent to the National Institute of Biomedical Research.

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

2:06 A.M.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8.9 FilmG259 3-24-60 at

CERTIFICATE OF DEATH

Reg. Dist. No.

01195

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY (a) 1b <u>1 1/2 hrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newcomb</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Edgar Parker Small</u>		4. DATE OF DEATH Month Day Year <u>January 3 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>George Washington Small</u>		14. MOTHER'S MAIDEN NAME <u>Julia B. Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>066-09-4445</u>	
17. INFORMANT <u>United States Army</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic occlusive</u> DUE TO (c) <u>coronary heart d.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cardiac failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-2-</u> , 19 <u>60</u> , to <u>1-3-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-3-</u> , 19 <u>60</u> , and that death occurred at <u>2:06</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Guy Reeser Jr.</u>		ADDRESS (Street, city or town, state) <u>St. Michaels, Md.</u>	
DATE SIGNED <u>1-4-60</u>		M.D.	
PHYSICIAN'S NAME (Type) <u>Dr. Guy Reeser Jr.</u>		DATE SIGNED <u>1-4-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 5 59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Smith</u>		24a. REC'D BY REGISTRAR	
ADDRESS <u>Easton Md</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 6 '60</u>		DATE <u>1-4-60</u>	

Arthur S. Hines

194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2709

CERTIFICATE OF DEATH

5005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>21 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>312 OAK ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Sudy</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 11, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTING</u>		11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>UNAVAILABLE</u>				14. MOTHER'S MAIDEN NAME <u>SUZAN PONYATOVSKY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>220-32-0914</u>		17. INFORMANT <u>Mrs. J. F. FRELAND, S. WASHINGTON ST. EASTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> Interval between onset and death <u>4-5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis; Diabetic Arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/6</u> , 19 <u>60</u> , to <u>1/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/7</u> , 19 <u>60</u> , and that death occurred at <u>4:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. J. Egisdor</u>				ADDRESS (Street, city or town, state) <u>12 N. HANSON ST. EASTON, MARYLAND</u>			
DATE SIGNED <u>1/7/60</u>							
PHYSICIAN'S NAME (Type) <u>L. J. EGISEDER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CMT.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thompson</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1194 CERTIFICATE OF DEATH

Reg. Dist. No.

01196

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>N. E</u> Last <u>Thieroff</u>		4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John J. Thieroff</u>		14. MOTHER'S MAIDEN NAME <u>Anna M Greenler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-7522</u>	
17. INFORMANT <u>Henreitta Milleman</u>		Address <u>Preston</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X Inanition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer (carcinoma) head of pancreas.</u> DUE TO (c) <u>Dec 59?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>60</u> , to <u>1/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/28</u> , 19 <u>60</u> , and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. B. Ambler</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Md</u> DATE SIGNED <u>1/30/60</u>	
PHYSICIAN'S NAME (Type) <u>J. B. AMBLER</u>		<u>Easton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/31/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Jr. O. U. A. M.</u>	22d. LOCATION (City, town, or county) (State) <u>Preston, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Hollis</u> ADDRESS <u>Preston, Md</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '60</u> 24b. REGISTRAR'S SIGNATURE <u>William L. Hanna</u>	

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Page 4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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CONFIDENTIAL

1184

1

CERTIFICATE OF DEATH

Reg. Dist. No.

01197

1195

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>CAROLINE</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>				d. STREET ADDRESS <u>Ridgely</u> <u>05 x - 2</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>WALKER</u> Last				4. DATE OF DEATH Month <u>JAN</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 8, 1888</u> 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State of foreign country) <u>Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Young</u>				14. MOTHER'S MAIDEN NAME <u>Ade Lia WALKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-22-8492</u>		17. INFORMANT Address <u>Rosa Walker Ridgely, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia (Arteriosclerotic heart disease)</u> 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days - 1 year - unknown.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Nephrosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 25</u> , 19 <u>59</u> , to <u>Dec 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 30</u> , 19 <u>59</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles H. Winnacott</u> M.D.				ADDRESS (Street, city or town, state) <u>Ridgely Maryland</u> DATE SIGNED <u>1/7/60</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES H. WINNACOTT</u>				(Seen Dec 31 thru 1/3/60 by <u>DR. D. BARTLEY, MD</u>)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>1-6-60</u>		<u>Denton Cemetery</u>		<u>Denton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Barwell</u>				ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Reg. Dist. No.

01198

1196

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u> 09X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>John</u> Last <u>Windsor</u>		4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25 1895</u> 164 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Bus Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dorchester Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Harper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>199-03-9551</u>	
17. INFORMANT <u>Miss Amy V. Windsor, Hurlock, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>603X</u> DUE TO <u>Gravely ill plus pathology</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>(2) Chronic atherosclerotic heart disease</u> (b) <u>(?)</u> (c) <u>(?)</u>		INTERVAL BETWEEN ONSET AND DEATH (-) (?) (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/23, 1959</u> to <u>1/7, 1960</u> , that I last saw the deceased alive on <u>1/7, 1960</u> , and that death occurred on <u>6:25 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hanson, Street, Easton, Md.</u> DATE SIGNED <u>Hanson, Street, Easton, Md.</u>			
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.		PHYSICIAN'S NAME (Type) <u>Thurston Harrison</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 9, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hurlock, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton & Son</u> ADDRESS <u>FEDERALSBURG</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 12 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>

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